

Return this form to:

# Notice of Examination (OCF-25)

*Use this form for accidents on or after November 1, 1996.*

<b>Claim Number:</b>	
<b>Policy Number:</b>	
<b>Date of Accident:</b> (YYYYMMDD)	

In response to your recent application for accident benefits or catastrophic impairment determination or as part of our review of entitlement to benefits that are currently being paid to you, we will be conducting an examination of you by one or more health professionals or a social worker or a person who has vocational rehabilitation expertise. The information listed below outlines the:

- type of examination that will be conducted;
- reasons for the examination;
- the name, professions and designations of the persons conducting the examination;
- whether your personal attendance is required; and
- the date time and location of the examination.

**Within 5 business days of receiving this notice, you are required to provide all reasonably available information and documents that are relevant or necessary for the review of your medical condition prior to your examination to the person or persons conducting the examination identified in Part 4 of this form.**

**Not participating in an examination may result in the application being rejected or benefits being suspended. A copy of the examination report and determination with respect to the application for accident benefits or your entitlement to ongoing benefits will be sent to you.**

## Part 1 Claimant Information

Date of Birth (YYYYMMDD)	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number      Extension
Last Name		First Name	Middle Name
Address			
City		Province	Postal Code
Special Needs (if applicable) <input type="checkbox"/> Mobility <input type="checkbox"/> Interpreter (Type:      ) <input type="checkbox"/> Other (specify)			
Representative (if applicable)		Address	
City		Province	Postal Code
Telephone Number      Extension	Fax Number		Email

## Part 2 Type(s) and Reasons for the Examination

Type(s) of Examination		
<input type="checkbox"/> Income Replacement Benefits  <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Post-104 Weeks Disability	<input type="checkbox"/> Non-Earner Benefits <input type="checkbox"/> Caregiver Benefits <input type="checkbox"/> Medical and Rehabilitation Benefits <input type="checkbox"/> Application for Approval of an Assessment	<input type="checkbox"/> Applicability of Pre-Approved Framework Guideline <input type="checkbox"/> Attendant Care <input type="checkbox"/> Catastrophic Impairment <input type="checkbox"/> Housekeeping and Home Maintenance <input type="checkbox"/> Other Benefits
Reasons and Description of the Examination		

**Part 3  
Arrangements  
for  
Examination**

Arrangements for Examination are: <input type="checkbox"/> Listed Below <input type="checkbox"/> Will Follow
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**Part 4  
Health  
Professional(s)  
Conducting  
the  
Examination /  
Date /Location**

Name	Profession or Designation	Speciality
Facility Name		
Address		
City	Province	Postal Code
Contact's Last Name		Contact's First Name
Telephone Number	Extension	Fax Number
Email		
Are You Required to Attend the Examination; <input type="checkbox"/> Yes <input type="checkbox"/> Not Required to Attend – File Review		
If yes, date and time of Examination;		
Location of Examination		<input type="checkbox"/> At Address Listed Above or at:

**Part 5  
Insurance  
Information**

Insurance Company Name	City or Town of Branch Office (if applicable)	
Address		
City	Province	Postal Code
Adjuster's Name		
Telephone Number	Fax Number	Email

**Part 6  
Insurer  
Signature**

If you have any questions or concerns about the examination or conflicts with the examination date or time, please contact your adjuster listed in Part 5.		
Name of Insurance Company Representative (please print)	Signature of Insurance Company Representative	Date (YYYYMMDD)